

DERMATOLOGY PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

altScripts Specialty Pharmacy
 1636 Miller Park Way, West Milwaukee, WI 53214
 Phone: 414-385-9500 Fax: 414-385-7200



Patient Information: please provide a copy of the patient's insurance card or information					
Patient Name:		DOB:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	HT:	WT:
Address:		City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's name:	ID#:		Group #:	
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List allergies:					
Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization					
Diagnosis / ICD-10: <input type="checkbox"/> Psoriasis / _____ <input type="checkbox"/> Psoriatic Arthritis / _____ <input type="checkbox"/> Chronic Idiopathic Urticaria / _____ <input type="checkbox"/> Hidradenitis Suppurativa / _____ <input type="checkbox"/> Other: _____					
PSO/PSA	Diagnosed with: <input type="checkbox"/> CHF <input type="checkbox"/> Latex Allergy <input type="checkbox"/> MS <input type="checkbox"/> Hep B/C <input type="checkbox"/> Malignancy			Affected areas: <input type="checkbox"/> palms <input type="checkbox"/> soles <input type="checkbox"/> head <input type="checkbox"/> neck <input type="checkbox"/> genitalia	
	TB/PPD test: Y / N Date of negative test: _____			% of BSA affected: _____	
	Patient is currently on therapy (Start date ____/____/____) Prior Therapies: Please include biologics, MTX, PUVA, topicals, UVB/NB/UVB and trials, including dates of treatment and reasons for discontinuation.				
Medication	Dose / Strength	Directions	Quantity	Refills	
<input type="checkbox"/> Cimzia® (PSO/PSA)	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 200 mg/mL prefilled syringe <input type="checkbox"/> 400 mg lyophilized vial	<input type="checkbox"/> 400 mg SQ weeks 0, 2 and 4 <input type="checkbox"/> 400 mg (given as 2 SQ inj of 200 mg each) every other week <input type="checkbox"/> 200 mg SQ every 2 weeks <input type="checkbox"/> 400 mg SQ every 4 weeks			
<input type="checkbox"/> Cosentyx® (PSO)	<input type="checkbox"/> 150 mg/mL single-use prefilled syringe <input type="checkbox"/> 150 mg/mL Sensoready pen	<input type="checkbox"/> 300 mg SQ weeks 0, 1, 2, 3, and 4, then 300 mg every 4 weeks			
<input type="checkbox"/> Dupixent® (atopic dermatitis)	<input type="checkbox"/> 200 mg/ 1.14 mL single-dose pre-filled syringe <input type="checkbox"/> 200 mg/ 1.14 mL single-dose pre-filled pen <input type="checkbox"/> 300 mg/ 2 mL single-dose pre-filled syringe <input type="checkbox"/> 300 mg/ 2 mL single-dose pre-filled pen	<input type="checkbox"/> ADULTS: Initial dose of 600 mg (two 300 mg injections in different injection sites), then 300 mg every other week <input type="checkbox"/> _____ KG PEDIATRIC, 6 YRS & OLDER:			
<input type="checkbox"/> Enbrel® (PSO/PSA)	<input type="checkbox"/> 25 mg/mL (latex free) <input type="checkbox"/> 50 mg/mL SureClick® autoinjector <input type="checkbox"/> 50 mg/mL prefilled syringe <input type="checkbox"/> 50 mg/mL solution in Enbrel Mini™ single-dose prefilled cartridge for use with the AutoTouch™ reusable autoinjector only	<input type="checkbox"/> 50 mg SQ twice weekly for 3 months <input type="checkbox"/> 50 mg SQ once weekly <input type="checkbox"/> Other:			
<input type="checkbox"/> Humira® - Citrate Free (Hidradenitis Suppurativa)	<input type="checkbox"/> Starter Kit - 80 mg / 0.8 mL <input type="checkbox"/> 40 mg/ 0.4 mL pens or prefilled syringes <input type="checkbox"/> 80 mg/ 0.8 mL pens	<input type="checkbox"/> Inject 160 mg SQ day 1; 80 mg day 15; two weeks later (day 29), begin a maintenance dose of 40 mg every week <input type="checkbox"/> Inject 40 mg SQ weekly and repeat in two weeks <input type="checkbox"/> Inject 1 pen (80 mg) SQ every two weeks and repeat in two weeks			
<input type="checkbox"/> Humira® - Citrate Free (PSO/PSA)	<input type="checkbox"/> Starter Kit - 80 mg / 0.8 mL and 40 mg / 0.4mL <input type="checkbox"/> 40 mg/ 0.4 mL pens or prefilled syringes	<input type="checkbox"/> Initial dose of 80 mg SQ, followed by 40 mg every other week starting one week after initial dose <input type="checkbox"/> 40 mg SQ every other week			
<input type="checkbox"/> Ilumya™ (PSO)	<input type="checkbox"/> 100 mg prefilled syringe	<input type="checkbox"/> 100 mg SQ day 0 and 28, then every 12 weeks.			
<input type="checkbox"/> Otezla® (PSO/PSA)	<input type="checkbox"/> Starter Kit <input type="checkbox"/> 30 mg tablets	<input type="checkbox"/> Taper per starter pack packaging <input type="checkbox"/> 30 mg PO twice daily <input type="checkbox"/> 30 mg PO once daily			
<input type="checkbox"/> Siliq™ (PSO)	<input type="checkbox"/> 210 mg/ 1.5 mL single-dose prefilled syringe	<input type="checkbox"/> 210 mg SQ day 0, 7 and 14, then every 2 weeks			
<input type="checkbox"/> Simponi® (PSA)	<input type="checkbox"/> 50 mg/ 0.5 mL SmartJect® autoinjector <input type="checkbox"/> 50 mg/ 0.5 mL prefilled syringe	<input type="checkbox"/> 50 mg SQ every 4 weeks			
<input type="checkbox"/> Skyrizi™ (PSO)	<input type="checkbox"/> 150 mg/mL single-dose autoinjector <input type="checkbox"/> 150 mg/mL single-dose prefilled syringe	<input type="checkbox"/> 150 mg SQ at weeks 0, 4 and every 12 weeks thereafter			
<input type="checkbox"/> Stelara® (PSO/PSA)	<input type="checkbox"/> 45 mg/ 0.5 mL prefilled syringe <input type="checkbox"/> 90 mg/ 1 mL prefilled syringe	<input type="checkbox"/> Inject 45 mg SQ days 0, 28 and then every 12 weeks <input type="checkbox"/> Inject 90 mg SQ days 0, 28 and then every 12 weeks			
<input type="checkbox"/> Taltz™ (PSO)	<input type="checkbox"/> 80 mg/mL prefilled syringe <input type="checkbox"/> 80 mg / mL prefilled autoinjector	<input type="checkbox"/> 160 mg SQ (two 80 mg injections) week 0, then 80 mg at weeks 2, 4, 6, 8, 10, and 12, then 80 mg every 4 weeks			
<input type="checkbox"/> Tremfya™ (PSO)	<input type="checkbox"/> 100 mg / mL prefilled syringe <input type="checkbox"/> 100 mg / mL One-Press patient-controlled injector	<input type="checkbox"/> 100 mg SQ day 0 and 28, then every 8 weeks			
<input type="checkbox"/> OTHER					
Prescriber Information					
Prescriber name:		Phone:		Office contact name:	
Prescriber address:			City:	State:	Zip:
NPI:	DEA:	Email / Fax:			
Signature:				Date:	<input type="checkbox"/> DO NOT SUBSTITUTE

Important Notice: This facsimile transmission is intended to be delivered only to the named recipient(s), and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named recipient, immediately notify the sender at the address and phone number set forth herein and obtain instructions as to properly dispose of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except authority of the sender to the named addressee.